State of California—Health and Human Services Agency

CHDP PROVIDER DATA SHEET
For Local CHDP Program Use Only

Local CHDP Program: _____   Date: _____   County code ☐☐

Prepared by: _____   Phone: (____) _____

Type or use blue or black ink.
Leave one space between words and no spaces between letters in a title.
Do not use punctuation except if hyphenated name.
Highlight in yellow all changes to information previously submitted

1. Transaction Code
   ☐
   1—New
   2—Change, Inactivate,
      or Reactivate

2. Primary/Secondary/Lab
   ☐
   1—Primary
   2—Secondary
   3—Laboratory

3. Category
   ☐
   1—Health assess. only
   3—Laboratory services only
   4—CCC with referrals
   5—CCC without referrals

4. A. Status Code and Date Effective
   ☐   1—Active   2—Inactive |__|__|__|__|__|__|
                                 Month   Day   Year
   B. ☐   Reason for Inactivation
          (See page 2 for codes)

5. Provider ID Number
   |__|__|__|__|__|__|__|__|

6. Type
   |__|__|

7. Tax or SSA Number
   |__|__|__|__|__|__|__|__|__|

8. Phone Number
   |__|__|__| |__|__|__|__|__|__|__|

9. Name and Office Address (Use only 30 characters, including spaces, per line)

   Name
   A. Last, First, Title

   Use line B ONLY when needed to extend name
   B.

   Office Address (Include suite/room number/letter)
   C. Street

   10.   L.A. County Area Code |__|__|

   D. City   State   ZIP Code |__|__|__|__| — |__|__|__|__|

11. Pay-to Name and Address (Use only 30 characters, including spaces, per line)

   "Pay-to" Name
   A. Last, First, Title

   Use line B ONLY when needed to extend name
   B.

   P.O. Box or "Pay-to" Address
   C. Street

   D. City   State   ZIP Code |__|__|__|__| — |__|__|__|__|

12. All other provider ID numbers active with Medi-Cal or CHDP
    A.

    Any provider numbers used previously with CHDP or Medi-Cal
    B.

13. CLIA number |__|__|__|__|__|__|__|__|__|__| Type: ☐ Waiver   ☐ PPM   ☐ Certificate   ☐ Accreditation

14. Signature of CHDP Program Director
   ➤

DO NOT WRITE BELOW DOUBLE LINE— FOR STATE USE ONLY

Comments:

Date received: _____   Date processed: _____   ☐ Letter bypass   ☐ CHDP Flag on Medi-Cal

PM 177 (2/03)   *SEE REVERSE FOR INSTRUCTIONS.*   Page 1 of 2

INSTRUCTIONS FOR COMPLETING PROVIDER DATA SHEET (PM 177)

Highlight in yellow all changes to information previously submitted. All items on PM 177 must be completed. This form is to be completed by the local CHDP Program.

1. **Transaction Code**
   1 = New—Enter code "1" when a provider is new to the CHDP Program, adds a new office site, or changes provider ID number.
   2 = Change—Enter code "2" when name or any other information previously submitted is changed, or a provider ID number is inactivated or reactivated.

2. **Primary/Secondary Code**
   1 = Primary Provider—Enter code "1" when approved provider is responsible for provision of all the health assessment components.
   2 = Secondary Provider—Enter code "2" when approved provider performs only vision and/or hearing testing.
   3 = Lab Provider—Enter code "3" when approved provider performs only laboratory services.

3. **Category Code**
   1 = Health Assessment Only—Enter code "1" to indicate approval to participate as Health Assessment Only Provider.
   3 = Laboratory Services Only—Enter code "3" to indicate approval to participate as laboratory services only provider.
   4 = CCC With Referrals—Enter code "4" to indicate approval to participate as a Comprehensive, Continuous Care Provider which will accept new patient referrals from the CHDP Program.
   5 = CCC Without Referrals—Enter code "5" to indicate approval to participate as a Comprehensive, Continuous Care Provider which does not accept new patient referrals.

4. **A. Status Code and Effective Date**
   1 = Active—Enter code "1" when approved to be a new provider or when reactivating a previous provider. Enter the date the provider can begin to provide services. (This date can be earlier than the date the PM 177 is submitted. The date must NOT be earlier than the provider's active date on the Medi-Cal file.)
   2 = Inactive—Enter code "2" when a provider or provider number is inactivated with the CHDP Program. Enter the date inactivated. (Contact the Children's Medical Services (CMS) Branch, Provider Services Unit to obtain inactivation date from Medi-Cal file.)

   B. Reason for Inactivation
   If item 4A is marked 2-Inactive, indicate the major reason for inactivation using the following codes:
   1 = Initiated by Medi-Cal
   2 = Noncompliance with CHDP Program standards
   3 = Moved out of area
   4 = Reimbursement issues
   5 = Dissatisfaction with program requirements
   6 = Declining client population in service area
   7 = Other

5. **Provider ID Number**
   Enter the provider's Medi-Cal provider number. If a provider does not have a Medi-Cal provider number, obtain a provider number from the CMS Branch, Provider Services Unit.

6. **Type**
   Enter the provider type code. Refer to the CHDP local Program Guidance Manual, "Branch Notification of Provider Data" chapter.

7. **Tax or SSA Number**
   Enter the federal tax ID number as verified by letter from Internal Revenue Service. If unavailable, use social security number.

8. **Phone Number**
   Enter the number for use to communicate with provider about claims.

9. **Name and Office Address (must match Medi-Cal file)**
   9A—Enter the provider's name and title.
   9B—Use this line only if necessary to extend name.
   9C and 9D—Enter the provider's office address including suite or room number.

10. **For Use by Los Angeles County Only**

11. **"Pay–to" Name and Address**
    11A—Pay-to name. Note: Enter "County Treasurer" as "Pay-to" for all county facilities.
    11B—Use this line only if necessary to extend name.
    11C and D—Enter the provider's P. O. Box or "Pay-to" address.

12. **Other Provider Numbers**
    12A—Enter all other active provider numbers used by this provider on the Medi-Cal and/or CHDP Provider Files.
    12B—Enter any provider numbers this provider has used previously with Medi-Cal and/or CHDP.

13. **CLIA Number**
    Enter CLIA number for all providers who perform laboratory services. Place an "X" in boxes for type of certificate.

14. **Signature**
    All PM 177s must be signed by the local CHDP Program Director.

INFORMATION SUBMITTED MUST MATCH THE INFORMATION ON THE MEDI-CAL PROVIDER FILE.

NEW PROVIDERS SHOULD NOT SUBMIT CLAIMS UNTIL WRITTEN NOTICE IS RECEIVED FROM THE STATE. PROVIDERS FOR WHOM CHANGES IN INFORMATION ARE SUBMITTED SHOULD EITHER HOLD THEIR CLAIMS OR USE THE OLD INFORMATION UNTIL THEY RECEIVE NOTICE THAT THE CHANGES ARE IN THE CHDP PROVIDER FILE.